PHARMACY PLUS
A DEMONSTRATION PROGRAM UNDER SECTION 1115

SUPPLEMENT B

STATE OF RHODE ISLAND
PHARMACY PLUS WAIVER APPLICATION

I. PROGRAM ELEMENTS

Income Adjustments – **Health Insurance Premium Disregard**: The $1,500 amount for the income disregard was selected as it is about 5% above the median annual premium costs for Medicare + Choice plans in the State. Out-of-pocket premiums for supplemental, and employer-based retirement plans in RI are generally somewhat lower. The State's goal in establishing the health care premium disregard is to both provide an incentive for enrollees to maintain alternative health coverage (i.e., a crowd-out measure) and to afford individuals who have high Rx costs, but income just over 200% of FPL, the opportunity to receive waiver benefits rather than spend-down to full Medicaid coverage using the flex-test.

Asset Limits: The State recognizes that asset limits are a valuable tool for ensuring that limited public resources are allocated to those with the greatest need. However, the State concluded that omitting an asset test will yield tangible benefits that far outweigh the attendant risks. In making this decision, the State considered, among other factors, the potential impact of an asset limit on: (1) scope and cost of providing coverage to particularly vulnerable segments of the target population; (2) recent experience with RIPAE, and (3) administrative ease and simplicity. Specifically:

- A significant percentage of RIPAE enrollees have income at or below 100% of FPL, but are ineligible for full Medicaid coverage due to assets. During any given year, a substantial number of individuals in this category become eligible for Medicaid as medically needy as result of high prescription drug costs. It is the State's hope that Rx coverage under the waiver will reduce their out-of-pocket health expenses, improve their health status and, in time, decrease the possibility they will spend down for full Medicaid benefits. As the State does not have reliable estimates of the waiver population's assets as a whole, it is not possible at this juncture to establish a targeted asset test that preserves eligibility for the individuals the **RIx +** program was intended to serve.

- RIPAE does not impose an asset limit. Although RIPAE offers coverage to individuals with income up to 420% FPL, less than 1/2 of the seniors eligible for the program are now enrolled (34,000 of an estimated 71,000). Moreover, of those who are enrolled, an average of about only one-third (13,500) used their RIPAE coverage during any given month in SFY 2002. The available data

indicate that many of those who have opted not to either enroll in or utilize RIPAE Rx benefits have some other form of prescription coverage. Accordingly, the State does not expect this trend to change even though prescription coverage under the waiver will be less costly to enrollees and more expansive.

- Including an asset limit or test as a component of the waiver eligibility process has the potential to increase significantly both administrative costs and complexity. The State is committed to establishing a relatively simple application process based on one now in place for RIPAE. Also, the fiscal crisis now confronting the State has resulted in the across-the board cuts in administrative costs and personnel expenditures. As a consequence, the State does not have the staff resources necessary to implement a multi-tiered asset test capable of being targeted effectively and implemented with ease.

II. Benefit Management

Third Party Liability: Information regarding the availability of other third party insurance will be obtained through the application process. TPL information will follow the same procedures that are now utilized for Medicaid beneficiaries.

Once TPL information is collected the insurer is contacted by the TPL Unit to verify policy number, effective date and coverage type. TPL information is also gathered via a series of tape matches with insurers. This information is posted into the MMIS. If there is a verified TPL segment for an individual, claims that fall within that segment are cost avoided. The provider is notified of the availability of other third party insurance and bills the other third party insurer. Once the other insurer processes the claim, the provider resubmits its claims to the Medicaid Program for wrap around coverage.

Pharmacy Benefit Management: The Department of Human Services has comprised a team of state staff, contractors and consultants to manage its pharmacy benefit program. Staff from DHS, Electronic Data Systems (EDS), Health Information Design (HID), and Heritage Information Systems contribute to manage the various tasks and functions necessary to insure high quality pharmacy services. EDS as the state's fiscal agent supports claim processing, provider relations and the Medicaid Management Information System functions. HID provides technical and professional support to the Drug Utilization Review Board. Heritage provides technical and professional support to the state's prior authorization process. The overall responsibility of managing the program resides within the DHS Center for Adult Health.

Prior Authorization: The State plans to use the prior authorization (PA) system now in place for Medicaid fee-for-service for the waiver population as well. The classes of drugs currently subject to prior authorization are disease-specific – i.e., targeted at particular illnesses or conditions like erectile dysfunction, obesity and attention deficit hyperactivity disorders for adults. Later this year, several additional therapeutic classes of drugs that will added to the prior authorization list, including Proton Pump Inhibitors and COX 2 NSAIDS.

The State Medicaid program will soon begin utilizing an electronic prior authorization system that was purchased on contract from a private firm. The system, called ***Smart PA***, in unique in several important ways. First, Smart PA provides point-of-service access to the medical criteria required to make prior authorization decisions through a pharmacy's PLS system. Once the pharmacist enters the Medicaid recipient's prescription into the PLS, Smart PA queries the State's MMIS to determine if the disease being treated, the patient's prior history, and other factors meet the conditions for approval. If PA criteria are met, Smart PA processes the claim for the Rx. If the PA criteria not met, or the information is missing the pharmacy will get a message to have the physician contact a call center for approval.

III. COORDINATION WITH OTHER COVERAGE

With the implementation of any new Medicaid eligibility expansion, there is always the possibility that a significant number of those in the target population will drop any alternative forms of private health care coverage they may have so they can take full advantage of the lower or no-cost publicly-funded program/benefit. When substitution of private coverage with public coverage occurs on a mass scale, it is know as the "crowd-out effect."

To reduce the potential for crowd-out, State policymakers have stated for the record that the **RIx +** pharmacy waiver coverage is to serve as a ***supplement to*** rather than as substitute for other forms of prescription drug and health care coverage. Specifically, R.I.L.G**.** 40-8-2.4, as amended by 2002 P.L., Ch. 65, Art. 24, directs the RI Department of Human Services to seek a Title XIX waiver to establish a pharmacy assistance program for State residents who are members of the target populations (age 65 and older; GPA and CMAP), have income 200% of FPL and below, and "***otherwise unable to pay the costs for medically necessary prescription drug medications***" (emphasis added*).*

In deliberations prior to the enactment of the law, several Rhode Island policymakers indicated that, given the State's tenuous fiscal situation and federal budget neutrality requirements, it would not be possible to sustain the **RIx+** waiver program and maintain current eligibility levels for full Medicaid coverage if a crowd-out effect emerged. The impact that substitution could have on overall health status was also cited as an area of concern, particularly if pharmacy-only **RIx +**waiver coverage was used as a replacement for, instead of an adjunct to, more comprehensive health care benefits through Medicare + Choice or employer-sponsored retirement health plans.

In sum, in both the authorizing statute and the discussions that led to its enactment, State policymakers have made it clear that the purpose of the **RIx +** waiver program is to provide pharmacy assistance to members of the target population who are uninsured (i.e., no Rx coverage) or underinsured (i.e., limited Rx benefit that is

insufficient to meet need). Although some level of substitution is in all likelihood unavoidable, the waiver proposal includes several features designed to limit the potential for a crowd-out effect. Rather than imposing eligibility restrictions like waiting periods that penalize individuals who drop other forms of coverage, the State has elected to utilize various incentives to maintain coverage including: a $1,500 income disregard for health insurance premium costs (see above); incentive payments, and wraparound coverage (see below).

Incentive Payment: During public meetings about the proposed waiver, members of the community expressed reservations about offering eligible low-income individuals the choice of a cash payment v. health benefit of considerably greater value. At issue is whether the financial hardships confronting many lower-income applicants will give them cause to opt for the $25 incentive payment rather than wraparound coverage, even in instances when their other Rx benefits were quite limited. RIPAE coverage would still be available for seniors in this group once their other Rx coverage was exhausted. However, there is concern that the program's narrower benefit and higher co-pays would provide them with insufficient relief in the event of catastrophic illness.

In response to these issues and concerns, the State elected to make the $25 incentive to maintain insurance available only to individuals with income above 150% FPL. The State's rationale is a follows:

- Studies which have examined similar issues in the human services policy arena have found that the propensity to choose cash payments over other forms of assistance decreases as income level increases from under 100% FPL until about 185% FPL and then levels-off.[1] Members of the State's Medicaid Consumer Advisory Council (CAC) indicated that these findings are consistent with the experience of many the providers who work with seniors and persons with disabilities. Thus, individuals in the target population with income above 150% should be less likely than those with lower income to make decisions about coverage v. incentive payments on the basis of problems with cash flow.

- Census data, as well as information from RIPAE and other sources, suggest that members of the waiver target population with income above 150% are more likely than those with lower income to have Medicare + Choice or employer-sponsored retirement/group health plans that include comprehensive Rx coverage. As a consequence, the supplemental Rx coverage available through RIPAE should provide an adequate safety net for individuals in this group who opt for the $25 payment rather than wraparound coverage.

As an additional safeguard, the State plans to adopt a "good cause " policy that, in a narrow range of circumstances, will allow individuals who accept the incentive payment to request an exemption from the one-year bar on waiver enrollment. For example, the

[1] See, for example: Tollen, L. **Purchasing Private Health Insurance through Government Healthcare Programs: A Guide for States.** (1999**:** Alpha Center).

factors likely to be considered legitimate reasons for requesting an exemption include: the onset of a catastrophic illness and a significant change in either income or health insurance status due to a death or a divorce.

Wraparound Coverage: For the last two years, wraparound coverage has been utilized effectively in the State's RIte Share Premium Assistance Program both as an incentive to maintain private coverage and mechanism for ensuring comparability of benefits. The benefits now available through RIPAE for individuals who have exhausted private Rx coverage have been delivered much like wraparound coverage and without contributing to substitution, or confounding enrollees unnecessarily, for nearly a decade. The State plans to build on its experience with these two programs when providing wraparound coverage to **RIx+** waiver enrollees with other forms of prescription drug coverage.

Waiver enrollees will receive a benefit card along with instructions explaining that they must present all Rx benefits cards to a pharmacist at the time a prescription is presented. Most seniors who are enrolled in RIPAE and/or health plans in addition to Medicare are familiar with this process. The State's Medicaid MMIS makes information available to the pharmacist indicating the scope of the waiver benefit and co-pay levels in much the same manner as do private insurers. Thus, the pharmacist will be able to determine at the point-of-service the Rx coverage available under the individual's private plan as well as the scope of wraparound coverage available under the waiver. State law requires pharmacists to explain to the enrollee, upon request, the manner in which various Rx benefits will be coordinated.

The RI Department of Elderly Affairs already has training materials and health insurance outreach specialists to assist seniors in the process of using multiple health benefit cards. The outreach specialists will also be able to provide information about the importance of maintaining alternative forms of health coverage, that provide more comprehensive benefits. The State hopes to make specialists available to CMAP and GPA recipients with other forms of coverage as well.

Over the next year, the State will be participating as a beta test site for an electronic prescribing program that will transmit Rx information from physicians to pharmacists using a secure, dedicated local area network. The ease in which wraparound coverage is administered will increase substantially once this system is in place and fully operational the next year.

Substitution by Insurers: The State recognizes that the success of its efforts to reduce the potential for substitution will be affected by trends in the commercial and Medicare + Choice market over which it can exercise little influence or control. Insurers in the State who serve the **RIx +** target population may modify the scope and cost of Rx coverage in the plans they offer, particularly to the elderly, to promote substitution (e.g. make other forms of coverage unaffordable by raising premiums, co-insurance, deductibles) and/or shift a greater share of the financial burden for Rx benefits to the State (e.g., increase State wraparound costs by through restricted formularies, setting lower benefit levels, increasing co-pays, etc.).

At this early point in the Pharmacy Plus Waiver Program, there is no data available about gaming in the commercial market from any of the states that have received approval for and begun implementation of their pharmacy waiver programs. ***As such, the State of Rhode Island would like to reserve the discretion to seek CMS approval for modifications in RIx + waiver program that will allow the State to respond effectively to changes in the commercial market that promote substitution.*** Such modifications may include the imposition of penalties (e.g., waiting periods) and other deterrents (e.g., annual deductibles similar to private plans) for substitution.

IV. COST-SHARING

In developing a cost-sharing strategy for the **RIx+** program, the State's principal objectives were as follows:

- Utilize a method of cost-sharing familiar to members of the target population that would not require costly modifications of existing information and financial systems;

- Set cost-sharing at or below the levels in place in RIPAE, CMAP and GPA and, to the extent feasible, maintain existing exemptions/exclusions included in these programs; and

- Promote the use of generic medications, encourage responsible utilization, and minimize costs.

To achieve these objectives, the State plans to use a point-of-service co-payment system for the **RIx+** waiver that is modeled on approach most common in the commercial market. The specifics of the system are outlined below.

Three-tiered Co-payments: Waiver enrollees subject to cost-sharing will be charged a flat fee for each prescription they fill at the point-of-service using a three-tiered co-payment system. As the chart below illustrates, the amount of the co-pay assigned to each tier varies depending on whether: (1) the medication is a name brand drug or generic substitute; and (2) the enrollee's annual utilization level is above or below $1,800 (State's share of cost excluding any enrollee co-pays).

RIx+ Co-payment Schedule			
	Tier 1 Generic	**Tier 2 No Generic**	**Tier 3 Name Brand**
Level 1- Below $1,800	$2	$10	$20
Level 2 $1,800 & up	$4	$12	$25

In keeping with the State's cost-sharing objectives, the co-payment rate for tier 1 medications has been set significantly lower than the rates for the other tiers 2 and 3 to encourage enrollees to fill prescriptions with generic drugs whenever available. As the State recognizes that there will be circumstances in which there is not a generic substitute for a particular medication, the tier 2 co-payment has been set lower than the rate for tier 3 so as not to penalize enrollees, but above the rate for tier 1 to reflect the higher cost of brand name drugs to the State.

The amount of the co-payment rate for each tier has been set to ensure that the cost-sharing obligations of the target population at present will not increase once they become enrolled in **RIx+** waiver. Seniors enrolled in RIPAE who would qualify for **RIx+** now pay 40% of the State's cost for every prescription filled. The waiver's three-tiered co-payment structure will reduce this amount to 13%, on average at Level 1, and about 35% once annual utilization reaches Level 2.[2] As is current practice in the State-funded program, CMAP participants who are enrolled in the waiver will not be required to pay a share of the cost for psychotropic medications. For all other prescriptions filled, however, CMAP-eligible enrollees will be subject to the **RIx+** co-payment schedule. GPA recipients will not be subject to cost-sharing unless utilization rates rise well-above projected levels. As indicated earlier, it has long been State policy to exempt from cost-sharing any individuals who qualify or receive cash assistance.

Although this multi-tiered and layer cost-sharing system may seem inordinately complex, the State is confident that the systems now in place, and under-development, for Medicaid recipients will ensure **RIx+** enrollees will have ready access to seamless prescription coverage. Moreover, the RI Departments of Human Services and Elderly Affairs plan to offer enrollees information and training on the scope and use of **RIx+** benefits prior to implementation as of the date the waiver request is approved.

Utilization Levels: The State established two levels of co-payments for the **RIx+** part of the broader effort to both promote responsible utilization of prescription medications and contain costs. The $1,800 demarcation between Level 1 and Level 2 co-payments was

[2] This figure is based on an analysis of recent prescription medication utilization patterns of Medicaid recipients 65 and older and the RIPAE population by tier co-payment levels. The State expects waiver enrollees Rx patterns to include a similar mix of generic and name brand medications given the incentives to use generic medications.

selected after examining at length the Rx utilization patterns of Medicaid recipients with characteristics similar to the target population. Currently, average State costs for Medicaid Rx coverage in this group is about $1,500 per recipient, per annum. After factoring in adjustments for inflation and the higher cost of medications for the CMAP and the chronically ill, the State determined that the average annual cost for providing coverage to each waiver enrollee, excluding co-payments, should be about $1,800.[3]

Given current Medicaid trends, the State does not anticipate that a significant number of enrollees will incur more than the estimated $1,800 annual average benefit. Accordingly, rather than cap the benefit once Rx costs reached this level, the State has opted to increase the amount of co-payments in each tier by a small amount. In choosing this strategy, waiver coverage for enrollees with high chronic illnesses and conditions will be preserved.

[3] This figure has not been reduced to reflect drug rebates or projected savings from prior authorization, coordination with other forms of coverage and benefits management.